

RESCISSION  
of a Collaborative Agreement for the  
Prescriptive Authority for Controlled Substances  
(CAPA -CS)

By signing and submitting this form to the Kentucky Board of Nursing, I hereby certify that the Collaboration Agreement for APRN Prescriptive Authority for Controlled Substances (CAPA-CS) between the parties listed below is rescinded as of this \_\_\_\_\_ day, in the month of \_\_\_\_\_, in the year of \_\_\_\_\_.

All information on this notification form must be completed or the notification form will be returned to you for completion.

\_\_\_\_\_  
APRN Last Name (print clearly)

\_\_\_\_\_  
Physician Last Name (print clearly)

\_\_\_\_\_  
APRN First Name (print clearly)

\_\_\_\_\_  
Physician First Name (print clearly)

\_\_\_\_\_  
Kentucky APRN License #

\_\_\_\_\_  
Physician License #

\_\_\_\_\_  
Practice Name

\_\_\_\_\_  
Practice Address

\_\_\_\_\_  
Practice City, State and Zip Code

This form must be signed by at least one of the parties listed above.

\_\_\_\_\_  
APRN signature

\_\_\_\_\_  
Physician signature

\_\_\_\_\_  
Date signed

\_\_\_\_\_  
Date signed

Upon completion of this form, please return to:

**Kentucky Board of Nursing  
312 Whittington Parkway  
Suite 300  
Attn: APRN Program Coordinator  
Louisville, KY 40222**